CSA System of Care Annual Report FY 2013

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Annual Report
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The Fairfax-Falls Church Community Policy and Management Team (CPMT) is the community's governing body for addressing the needs of children and youth with serious emotional disturbance. Their mission is "to provide leadership in the development of new concepts and approaches in the provision of services to children, youth and families." The primary focus of the CPMT is to lead the way to effective and efficient services for the children already or at risk of experiencing emotional/behavioral problems, especially those at risk of or in need of out of home placements, and their families. Their philosophy is that "the most important community responsibility is the well-being of children. Children belong with families who nurture and protect them, children deserve healthy relationships, and families deserve to live in safe environments."

In 2008, a Systems of Care (SOC) Reform initiative was undertaken by the CPMT to address the community's difficulty in meeting the needs of youth and families with the most complex issues and highest risk factors, as evidenced by the increasing number of youth in long-term residential and group home care. One of the first achievements of the SOC initiative was the founding of Leland House, a partnership with United Methodist Family Services to provide short-term residential crisis stabilization to prevent unnecessary hospitalization or residential placement.

In 2010 the Fairfax-Falls Church CPMT initiated a new service of Intensive Care Coordination (ICC) for children/youth in or at-risk of residential placement, and family partnership meetings for children/youth in or at risk of foster care placement. CPMT contracted with the Fairfax-Falls Church CSB for ICC with a capacity of up to sixty families on an ongoing basis. In early 2013 ICC capacity was increased to eighty families through a contract with United Methodist Family Services. The Fairfax-Falls Church CPMT is firmly committed to providing intensive care coordination for children who at in or at risk of out of home placements.

CSA: Purpose and Intent

The Comprehensive Services Act for At-Risk Youth and Families (CSA) is a Virginia law (§2.2-5200) enacted in 1993 to address the rising cost of residential treatment for high-risk youth. It was the stated intention of CSA to create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youths and their families in the Commonwealth. The purpose includes the following key objectives:

- ***Ensure that services and funding are consistent with the Commonwealth's policies of preserving families and providing the appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public:***
- ***Identify and intervene early with young children and their families who are at risk of developing emotional or behavioral problems, or both, due to environmental, physical or psychological stress;***
- ***Design and provide services that are responsive to the unique and diverse strengths and needs of troubled youths and families;***
- ***Increase interagency collaboration and family involvement in service delivery and management;***
- ***Encourage a public and private partnership in the delivery of services to troubled and at-risk youths and their families; and***
- ***Provide communities flexibility in the use of funds and to authorize communities to make decisions and be accountable for providing services in concert with these purposes.***

From the beginning, ICC in Fairfax-Falls Church was based on the wraparound model. A November 2009 report to the CPMT by the inter-agency System of Care Services Committee recommended that ICC be provided using high fidelity wraparound. Those recommendations were incorporated into the ICC contract with CSB. In early 2011 the first team of intensive care coordinators participated in 24 hours of wraparound training provided by the Maryland Institute for Innovation & Implementation. In the Summer of 2013 all Fairfax-Falls Church intensive care coordinators participated in state-sponsored high fidelity wraparound training. To date 85% of youth at risk of placement who participated in ICC were successfully maintained in the community.

Concurrent with these activities to improve services and service planning processes, CPMT focused on changing the values and principles underlying the local child-serving system. In 2009 CPMT endorsed national system of care principles as the basis for serving children and youth with complex emotional and behavioral issues in the Fairfax-Falls Church community. In 2010 the number of CPMT parent representatives was doubled, from two to four. In 2011 CPMT approved detailed practice standards for integrating SOC principles into child-serving programs and processes. In 2012 CPMT approved a re-design of local team-based planning processes to better implement wraparound principles and practice standards such as family-driven care, team-based processes, individualized service planning and a strength-based approach. In late 2012 CPMT approved a comprehensive system of care training plan for staff at all levels and in all systems. In July 2013 the CPMT submitted a successful proposal to DBHDS to partner with a family organization to provide parent support partners to families in ICC. This commitment of key leaders and stakeholders to a common mission, vision and goals for serving youth and families has resulted in improved outcomes.

Outcome goals were established for the CSA system of care focused on measures of:

- Restrictiveness of living
- Youth and family functioning
- Permanency preservation for families
- Fiscal accountability

In March, 2014, the CPMT was recognized at the 3rd annual state CSA Conference as the outstanding local System of Care for demonstrating sustained excellence in bringing the vision of CSA as a system of care to life through the following actions:

1. Collaboration with multiple agencies, providers and consortiums to bring evidence based treatment to the community to address service gaps in the area;
2. Collaboration with natural supports to help the youth and his/her family faced with multiple service needs to keep the child in the community;
3. Demonstration of a commitment to integrating the values and principles of systems of care with individualized comprehensive care, family focused, family voice and choice, evidence-based practices, and community-based services.

Summary of Annual Performance Measures for FY 2013

The CSA program, along with the county's human services agencies, has begun implementing the Results-based Accountability framework for outcomes reporting and performance plans. The CPMT has adopted the following goals and measures for the FY 13 Performance Plan for CSA.

How Much Was Done?	
1.1	Total Youth Served Annually
1.2.1	Annual CSA Pool-fund Expenditures
1.2.2	Annual CSA Expenditures by Service Type
How Well Was It Done?	
2.1	**Restrictiveness of Living Outcome Goal 1: Increase in percentage of youth participating in CSA who live in family settings.**
2.1.1	Number of youth in a long-term congregate care setting
2.1.2	Percentage of youth participating in Intensive Care Coordination who are successfully prevented from entering residential or group home placement six months and twelve months after initiation of services
2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**
2.2.1	Average number of days (length of stay) CSA participating children live in congregate care – measured in current setting and at post-discharge
2.2.4	Percentage of youth participating in Intensive Care Coordination who are successfully returned from residential or group home placement within three months of initiation of services
2.4	**Fiscal Accountability Outcome Goal 1: Fairfax-Falls Church CSA leverages state and local fiscal resources to serve youth and families efficiently**
2.4.1	Per capita cost per youth receiving CSA services
2.4.2	Per capita cost per youth receiving residential/ group home services
2.4.3	Annual per-child unit cost of residential/group home services
2.4.4	Use of Medicaid is maximized as an alternative to CSA or locality funding
2.5	**Parent Satisfaction Survey**
2.6.1	Percent of parent survey respondents who are satisfied with CSA services
Is Anyone Better Off?	
3.1	**Restrictiveness of Living Outcome Goal 1: Increase in percentage of children participating in CSA who live in family settings.**
3.1.1	Percentage of CSA youth who received only community-based services

3.2	**Permanency Outcome Goal: Prevent entry into foster care for reasons other than maltreatment.**
3.2.1	Percentage of children receiving CSA-funded services through the foster care prevention mandate who are successfully prevented from entering foster care
3.2.2	Percentage of children with families participating in CSA-funded family partnership meetings through the foster care prevention mandate who are successfully prevented from entering foster care after the family partnership meeting
3.3	**Functional Outcome Goals: Child and Adolescent Needs and Strengths (CANS) outcomes improve for children served by the CSA system of care from initial assessment to second assessment.**
3.3.1	Percent of positive change in CANS outcomes by domain level of need
3.4	**Functional Outcome Goal 1: Children participating in CSA-funded services will experience a decline in behaviors that place themselves or others at risk.**
3.4.1	Percent of positive change in child risk behavior by actionable rating
3.5	**Functional Outcome Goal 2: Children participating in CSA-funded services will experience a decline in behavioral or emotional symptoms that cause severe/dangerous problems.**
3.5.1	Percent of positive change in Behavioral/Emotional Needs by actionable rating
3.6	**Functional Outcome Goal 3: Children participating in CSA-funded services will experience an increase in identified strengths that are useful in addressing their needs and developing resiliency.**
3.6.1	Percent of positive change in Strength Domain by actionable strength
3.7	**Functional Outcome Goal 4: Needs and issues of parents/caregivers of children participating in CSA-funded services that negatively impact their care-giving capacity will be reduced.**
3.7.1	Percent of positive change in planned permanent caregiver functioning by actionable need

Scope of Annual Report

System change has occurred at many levels of service delivery within our child-serving agencies and schools. This report cannot adequately reflect the valuable work of agency staff and the significant progress achieved within individual agencies and at other levels of the system as a whole. This report, therefore, is limited in scope to describing the impact of the system of care initiative on the CSA program and the current status of the SOC initiative as it relates to CSA functions. The source of data for this report is from the CSA information system and the state CSA website.

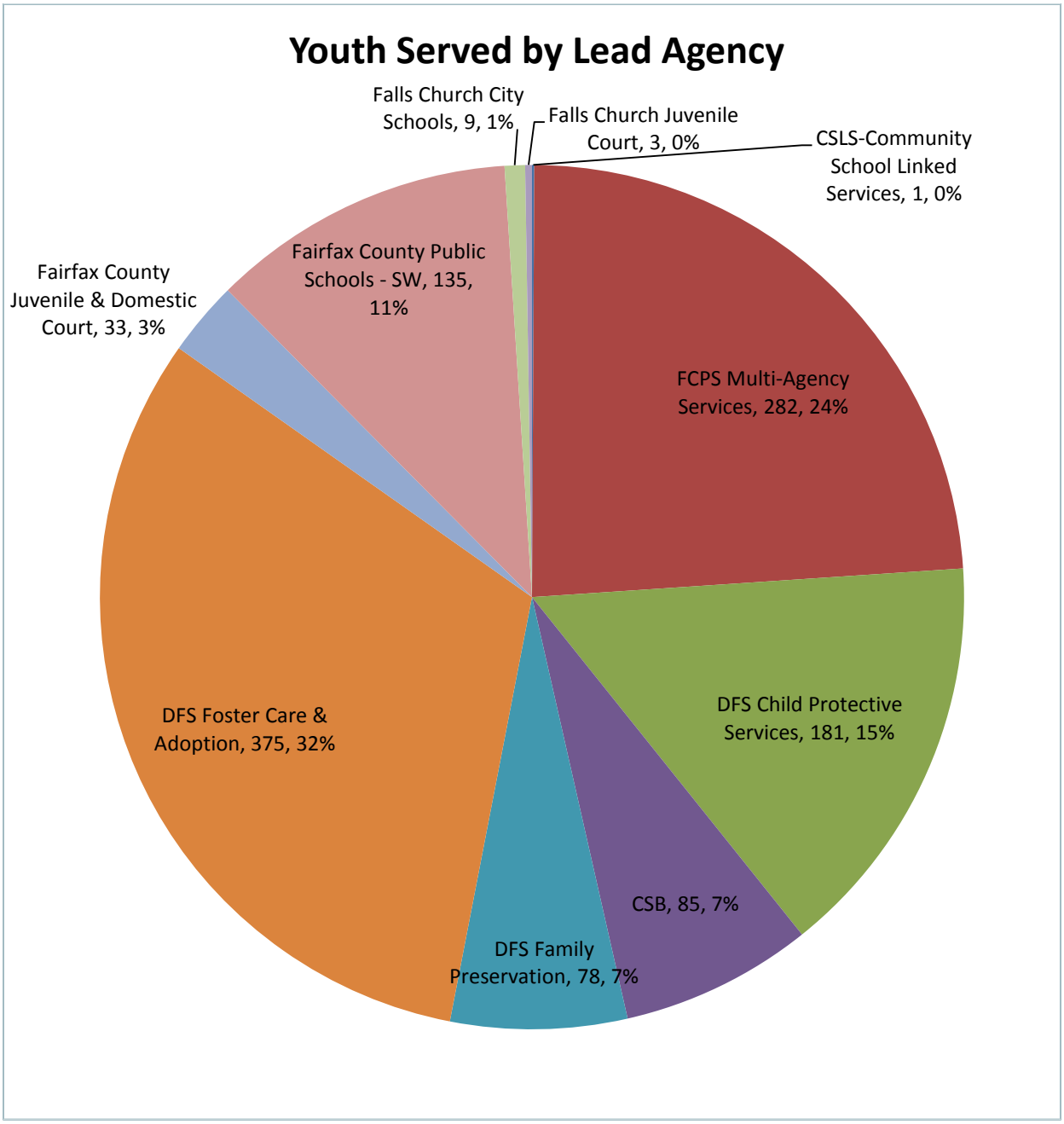
Youth served annually through CSA in our locality

The following table summarizes demographic characteristics of youth served in CSA in recent fiscal years. The number of youth served by CSA in FY 2013 was 1,199 which represents a decrease of 52 youth or 4% fewer youth served than the prior year. The majority of youth served are over the age of 12 (65%) and are predominantly male (58%). Over the last few years, the number of Asian youth served has increased to 5%, and the number of youth identified as Hispanic has increased to 10%.

	2007	2008	2009	2010	2011	2012	2013
Age							
0 to 3	10%	10%	9%	10%	9%	8%	9%
4 to 6	7%	6%	6%	6%	7%	6%	7%
7 to 12	21%	22%	21%	21%	21.5%	23%	20%
13 to 17	44%	41%	43%	41%	41%	39%	45%
18 to 21+	17%	20%	21%	22%	21.5%	24%	20%
Gender							
Male	58%	60%	58%	59%	59%	60%	58%
Female	41%	40%	42%	41%	41%	40%	42%
Race							
White	51%	52%	51%	52%	55%	55%	53%
Black/African American	33%	32%	31%	28%	26%	26%	23%
Asian	0%	0%	3%	3%	4%	4%	5%
Other	14%	17%	14%	16%	15%	14%	19%
Hispanic	13%	11%	11%	10%	8%	7%	10%
Referral Source							
Family Services	26%	38%	42%	48%	51%	54%	52%
Education	8%	12%	20%	23%	26%	26%	31%
Juvenile Justice	2%	5%	6%	6%	5%	4%	4%
CSB	1%	3%	4%	6%	6%	8%	7%
Interagency	60%	39%	26%	17%	12%	8%	0%
Family	0%	0%	0%	0%	0%	0%	0%
Other	2%	1%	1%	1%	0%	0%	6%
Health Department	0%	0%	0%	0	0%	0%	0%
Total Youth Served	**1110**	**1076**	**1121**	**1090**	**1191**	**1251**	**1199**

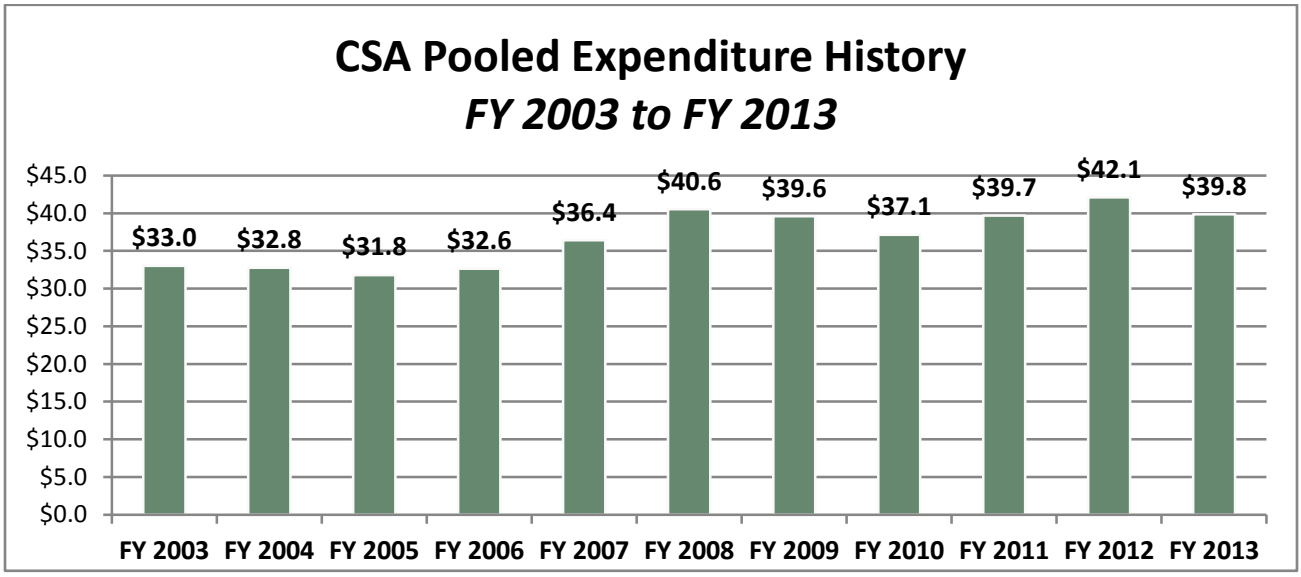
Youth and their families may access the CSA System of Care through schools and human services agencies

The CSA System of Care is designed to allow for broad access by youth and their families who meet the eligibility criteria. This past year, 252 different county and school staff representing 10 agencies and programs served as lead case manager for at least one CSA-funded youth. The Department of Family Services is the largest referral source (54%) followed by FCPS Multi-Agency Services (24%). School social workers managed 11% of CSA cases compared to 7% from the CSB and 3% from the court system.

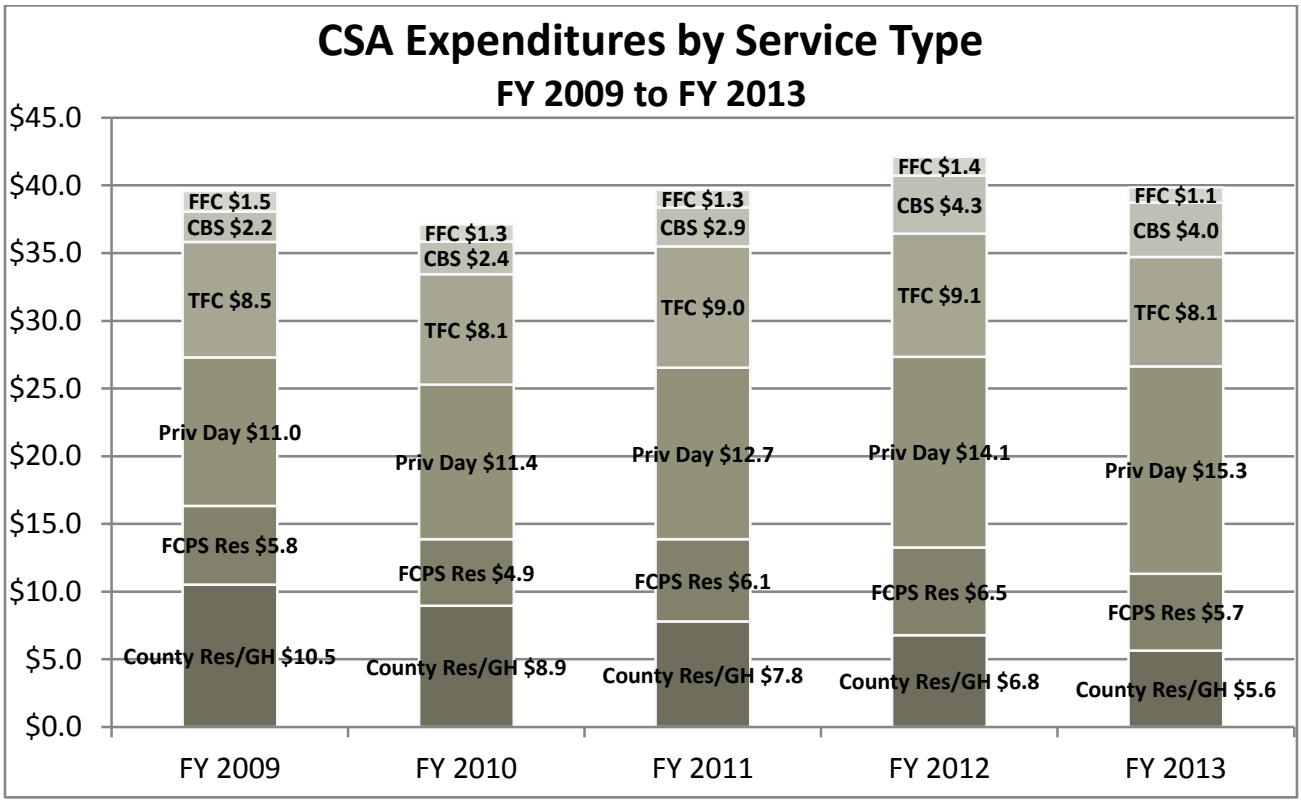


Total CSA expenditures decreased in FY 2013

Annual expenditures for the past ten fiscal years are shown below. CSA expenditures in FY 13 were $39.8 million, a decrease of $2.3 million from the previous fiscal year.



Expenditures by service type reflect two trends: 1) a shift of fiscal resources from residential services towards family and community-based services and 2) cost increases for private special education day services. Since 2009, community-based service expenditures have increased by $1.8 million while expenditures for residential placements have decreased by $4.9 million.

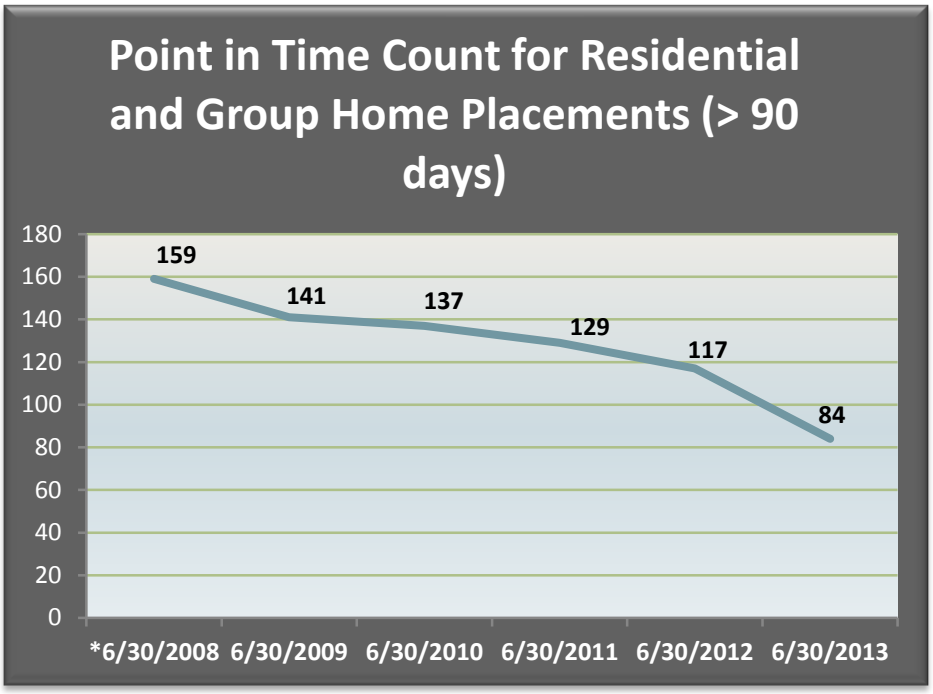


FFC – Family Foster Care; CBS - Community-based Services; TFC - Treatment Foster Care; Priv Day - Private Day School (IEP); FCPS Res - Residential School (IEP); County Res/GH - Residential or Group Home

Restrictiveness of Living Goal 1: Increase in percentage of youth participating in CSA who live in family settings

Placements in long-term group home and residential settings have continued to decline.

- The Point in Time count at the end of FY13 was 84, a 28% decrease in long-term out of home placements. The target of 10% decrease was met.
- A total of 212 youth received residential services in FY13 compared to 266 in FY12.
- Compared to the total number of youth served by CSA, 82% of CSA-funded youth lived in non-residential settings compared to 79% in FY12.



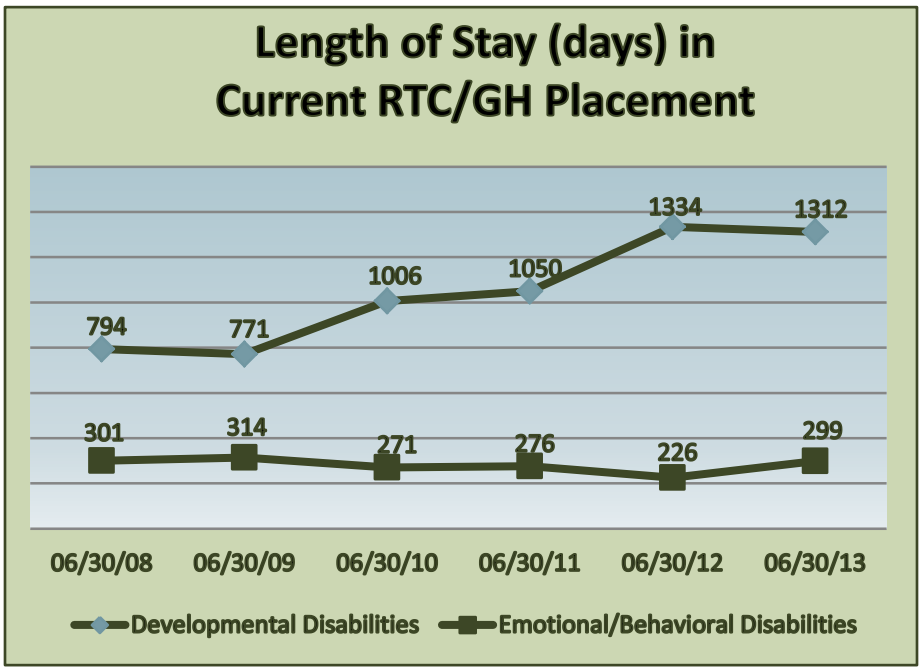
Restrictiveness of Living Goal 2: Youth who require out of home services shall be returned as quickly as possible to a family setting

Best practice indicates that for youth with emotional/behavioral problems, the length of stay in residential should be no longer than 6-9 months.

- For FY 13, the average length of stay for youth in their current placement was 299 days, an increase of 32% compared to the end of the last fiscal year. The targeted decrease of 10% was not achieved.

For youth with developmental disabilities, the number of youth placed in long-term facilities has decreased by 5 youth (20%) but length of stay targets have not been met for this population.

- Length of stay was 1312 days in current placement (n = 20 as if 6/30/13), which is a 2% decrease from the previous year.



Intensive Care Coordination supports youth to remain in their family and community or return to their family as soon as possible

Our system of care is served by two providers of Intensive Care Coordination services: the Community Services Board operates Wraparound Fairfax with a staff of six care coordinators and United Methodist Family Services (UMFS) operates a two staff unit through their Leland House program. Capacity for ICC was expanded this fiscal year with the addition of the UMFS ICC program. A total of 104 youth received ICC services in FY13. Both providers utilize the evidence-based practice of High-fidelity Wraparound and received standardized training in this state-endorsed model. Beginning in FY14, wraparound fidelity monitoring will be provided by an outside consultant to ensure that services are delivered according to the model.

Restrictiveness of Living Goal 1: Percentage of children participating in intensive care coordination who are successfully prevented from entering residential or group-home placement six months and twelve months after initiation of services.

- Of the youth who were referred to ICC to prevent residential placement, 83% (n=93) remained in the community 6 months after ICC initiation. 73% remained in the community twelve months after ICC initiation. The targets of 85% and 75% at 6 months and 12 months were not met.

Restrictiveness of Living Goal 2: Percentage of children participating in intensive care coordination who are successfully returned from residential or group home placement within three months after initiation of services.

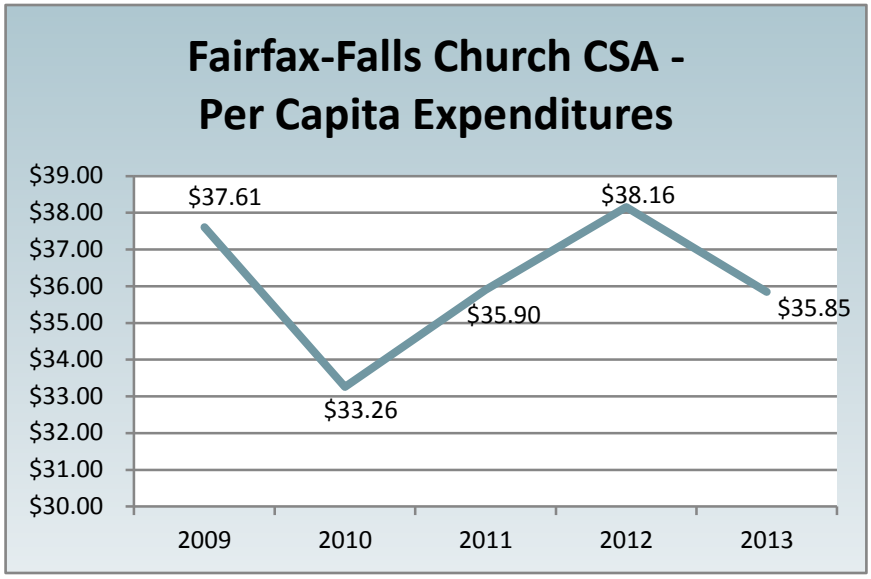
- For youth referred for ICC services to support the youth in returning to the community from residential placement, 4 out of 8 (50%) returned to the community from residential placement within 3 months of ICC initiation. The target of 70% was not met.

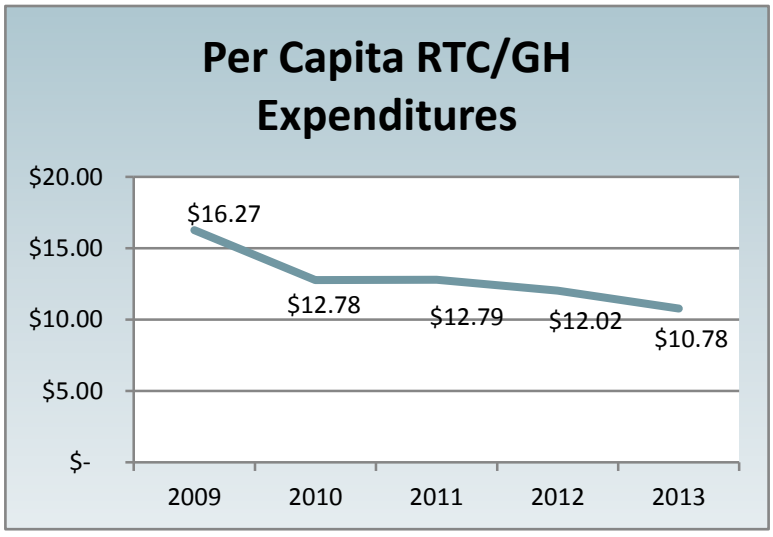
Intensive Care Coordination (ICC) is a family-driven, youth-guided, team-based approach to help youths and their families who are at-risk of out-of-home placement. ICC follows guiding principles from the wraparound approach:

- **All children need and deserve loving, permanent homes and family connections.**
- **Safety comes first.**
- **Parents and families have the right and responsibility to raise their own children.**
- **Services should be planned in a way that honors and reflects the family's values and preferences.**
- **Whenever possible, children and youth need to be served in their community.**
- **If a placement outside the community is necessary, it needs to be as brief as possible. The ICC team will help the family find and develop the supports needed to make sure that the child's return home is safe and successful.**

Our System of Care leverages state and local fiscal resources to serve youth and families efficiently

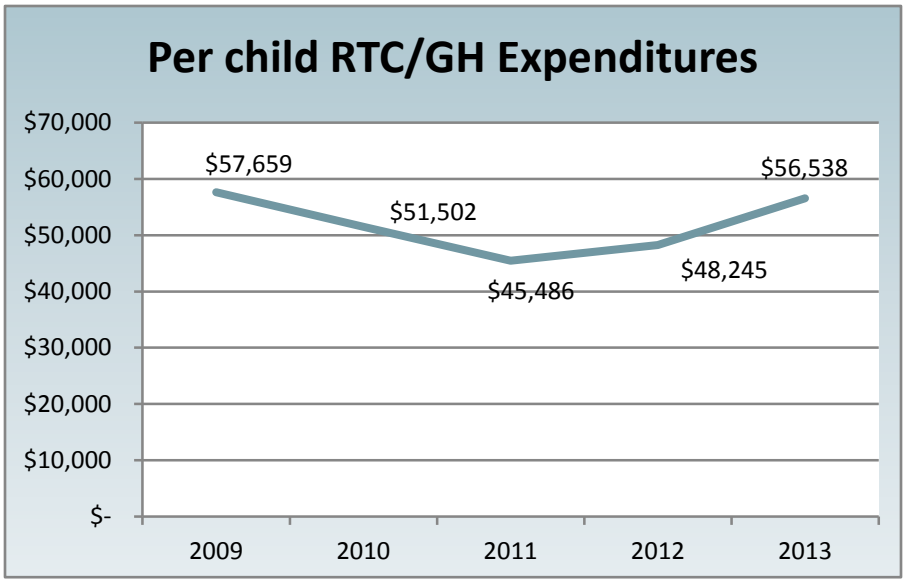
- The per capita cost per youth receiving CSA services decreased this fiscal year to $35.85.





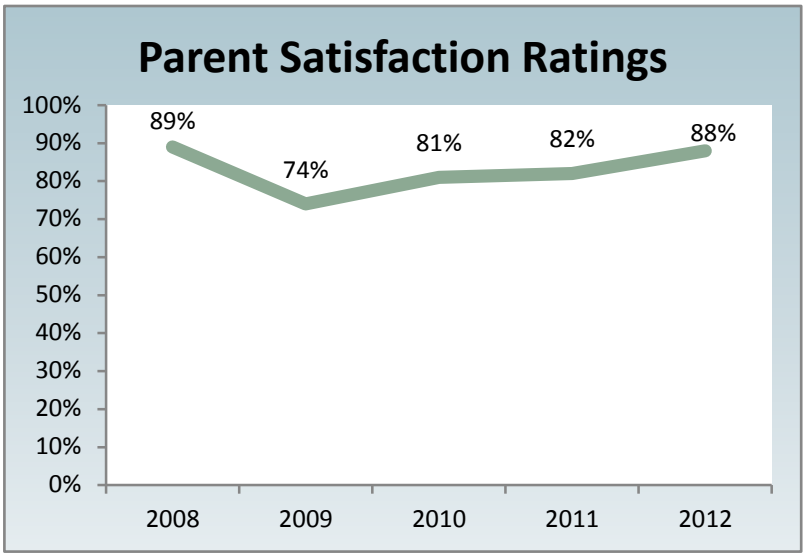
- The per capita cost for youth receiving residential/group home services has decreased to $10.78.

- Annual per-child unit cost of residential/group home services



Parents are generally "Satisfied" with CSA-funded services

At the end of each fiscal year, parents of youth who have received services under the Foster Care Prevention, Special Education, and Non-mandated funding categories receive a survey asking them to rate their satisfaction with CSA services. Families involved with DFS through Child Protective Services and Foster Care and Adoptions are not included in the survey due to the sometimes involuntary nature of their service plans. The survey solicits family feedback about the perceived helpfulness of services, their participation in the planning process, respect shown to families by staff, and the perceived quality of services provided. The satisfaction ratings are calculated by averaging each person's response, then the number of Positive Response (3.0 or better) is divided by Total Responses for an Overall Rate of Positive Response. 120 families completed and returned the survey, yielding an overall satisfaction rating of 88%.



The System of Care supports foster care prevention services

Preservation of Permanency Goal: Prevent entry into foster care for reasons other than maltreatment.

- 470 out of 505 youth (93%) of the youth who received services under the CSA foster care prevention mandate remained in a family setting, compared to 371 of 432 youth (86%) in FY12
- 241 out of 260 youth (93%) who received a family partnership meeting under the CSA foster care prevention mandate were successfully prevented from entering foster care, compared to 124 of 147 youth (84%) in FY 12

The Department of Family Services Children, Youth and Families (CYF) Division began the Family Partnership Program on July 1, 2010. This program reflects the extensive work by state and local child welfare representatives for over two years to modify practice to more effectively support and strengthen permanent family connections for children and families. The decision to launch this new program significantly increased the capacity of DFS to partner and support families in their efforts to care for their children, thus reducing out-of-home placements and increasing relative and community placement.

In FY 12, the Fairfax-Falls Church CPMT approved a team-based planning approach as best practice for serving youth with significant behavioral or emotional challenges which are present in several settings such as home, school or in the community and requires services/resources that necessitate collaboration among multiple

CANS Overview

The Child and Adolescent Needs and Strengths (CANS) assessment is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Case managers, along with youth, families and other stakeholders, complete the CANS as part of the service planning process and CANS ratings are required at defined intervals by service type throughout the duration of service provision.

The CANS contains six domains: Life Domain Functioning, Child Strengths, School, Caregiver Strengths and Needs, Child Behavioral/ Emotional Needs, and Child Risk Behaviors. Each of the items within the domains is rated along a continuum: 0 = No evidence; 1 = Watchful waiting/prevention; 2 = Action; 3 =Immediate/Intensive Action. The Child Strengths Domain is rated: 0 = Centerpiece strength; 1 = Strength useful in planning; 2 = Strength identified but must be developed; 3 = No strength identified.

– Praed Foundation

Services provided to youth and their families have resulted in positive functional outcomes

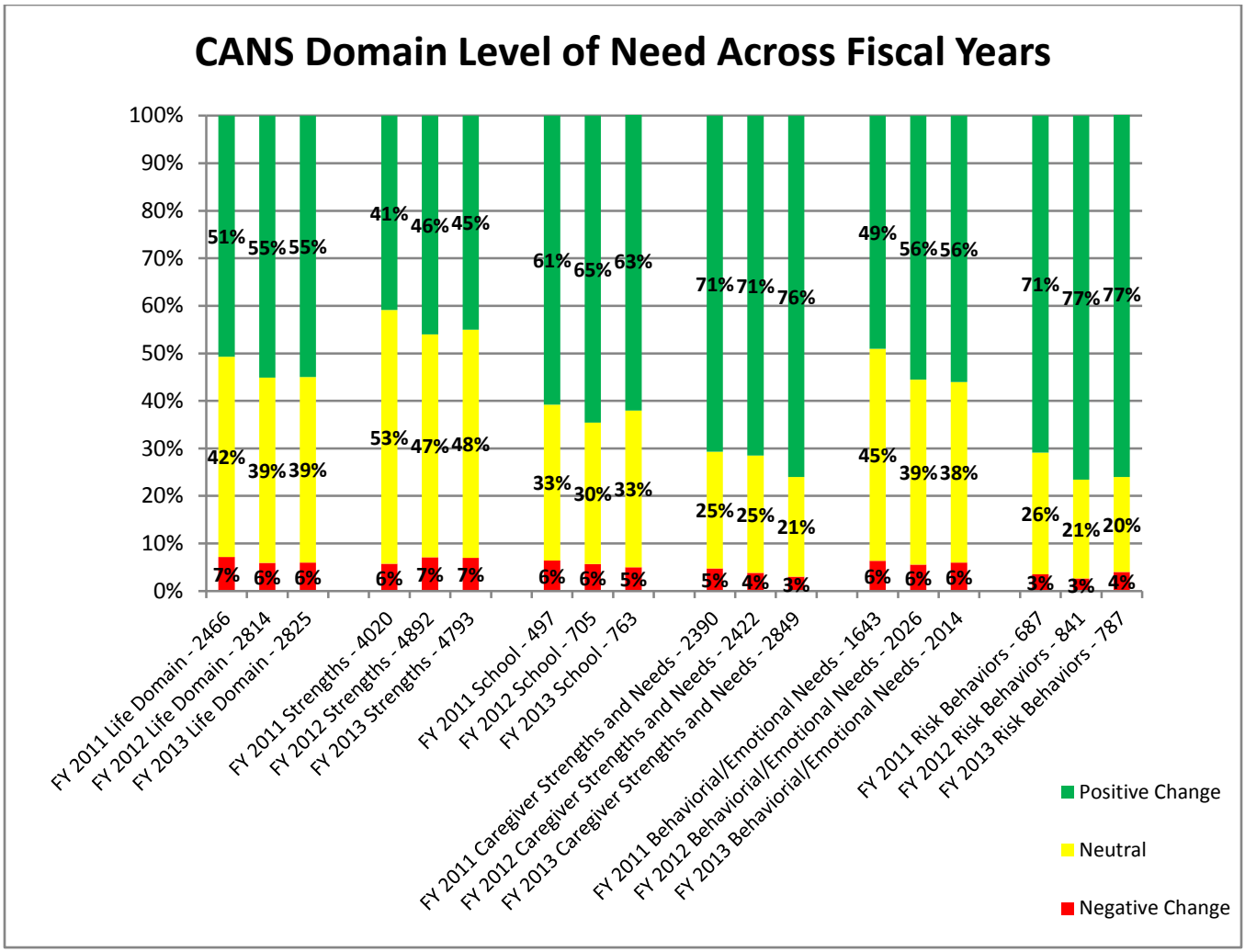
Youth and family outcomes were measured using the Child and Adolescent Needs and Strengths (CANS) Assessment[1] tool that was adopted by Virginia as the mandatory uniform assessment for all CSA-funded youth beginning July, 2009. The analysis of youth and family outcomes was conducted by comparing the initial CANS ratings upon entering the CSA system of care to the youth's most recent rating in FY 2013 for youth aged 5 or older. Of the 1,199 youth served in FY 2013, there were 837 youth who had two CANS assessments that would allow for comparison. Only items with ratings of 2 and 3 (moderate and severe) which are considered the "Actionable" level of need were included in the analysis to determine the percentage of youth where the target behavior(s) were rated as improved/better, stayed the same, or were rated as worse. Each chart indicates the prevalence of the need within the youth sampled. Outcomes were calculated at the Domain level which averages the percentages of improvement (better, same, worse) across the items. Outcomes were also calculated at the item level by Domain.

[1] For more information about the CANS see http://praedfoundation.org/About%20the%20CANS.html

Youth and Family Outcomes across CANS Domains

CANS analyses have been conducted for the past three fiscal years allowing for a comparison of overall domain ratings over three years for our system. These cross year comparisons show stability in the pattern of measured improved functioning for youth and families served by the system of care. Youth Risk Behavior, Caregiver Strengths and Needs followed by School Behavior have shown the most improvement with services over time.

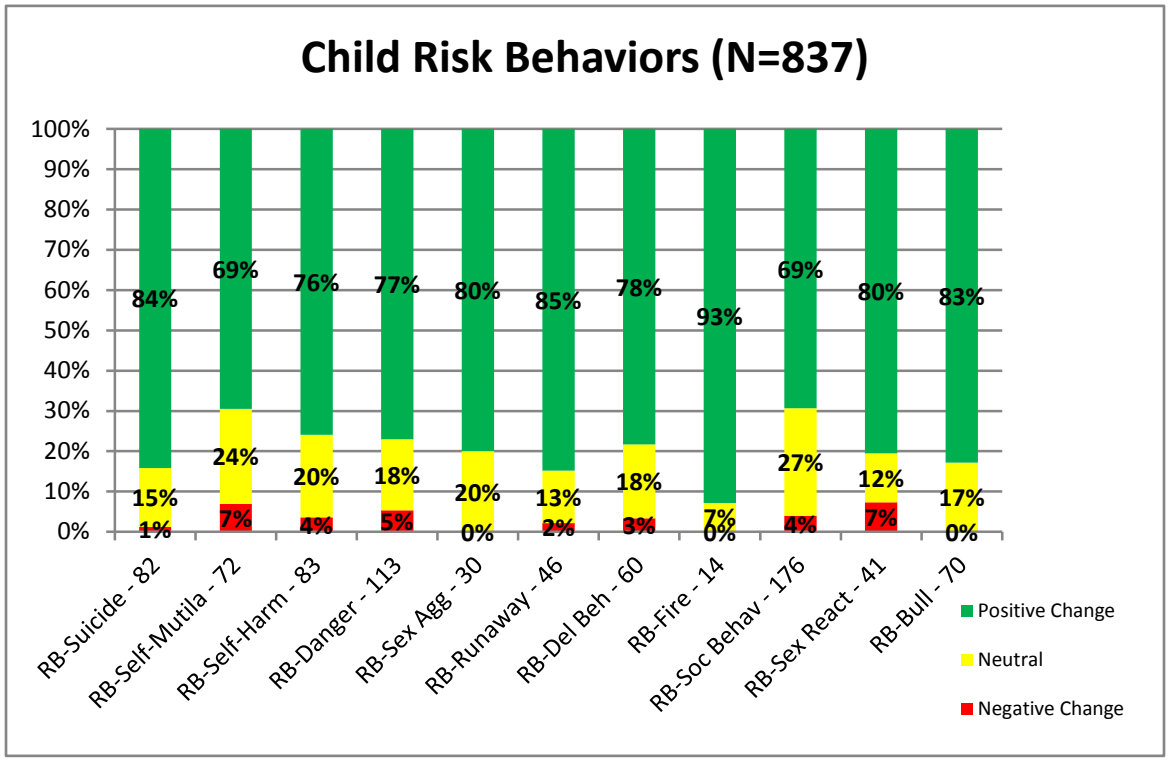
Functional Outcome Goals: Child and Adolescent Needs and Strengths (CANS) outcomes improve for children served in the CSA system of care from initial assessment to second assessment



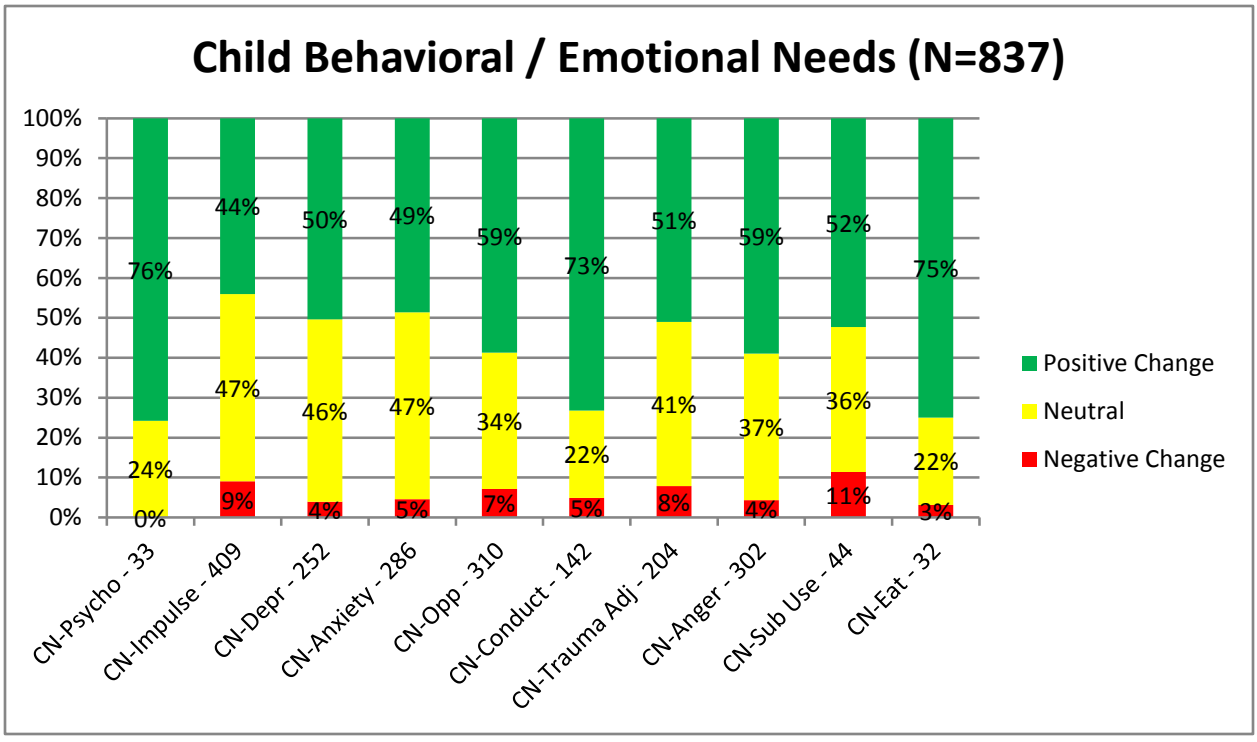
The comparison of the initial and most recent CANS in FY 13 indicates that 77% of youth improved on risk behaviors, 76% of the caregivers were rated as improved, and 63% of youth were rated as improved in the school domain. Targets for FY13 were established for increases of 3 percentage points on Risk Behaviors and Caregiver domains and 6 percentage points for Behavioral/Emotional and Child Strengths. The target for caregiver was met .

Youth outcomes within CANS domains

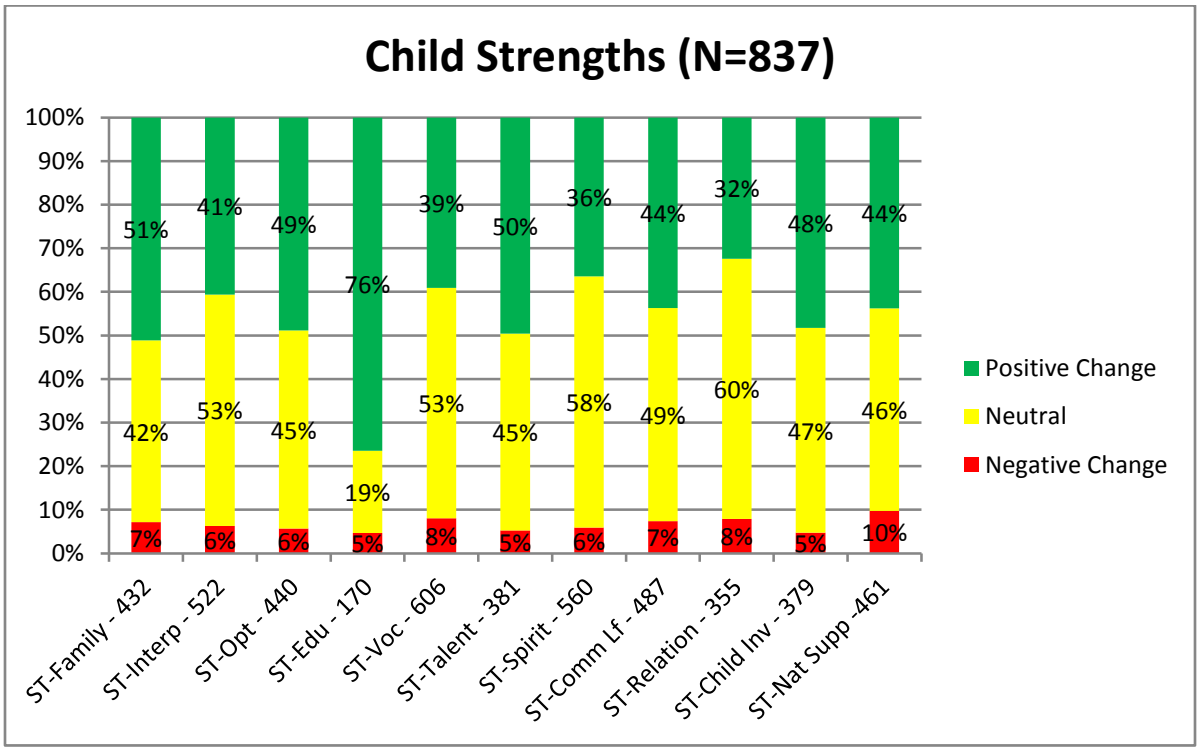
Functional Outcome Goal 1: Children participating in CSA-funded services will experience a decline in behaviors that place themselves or others at risk



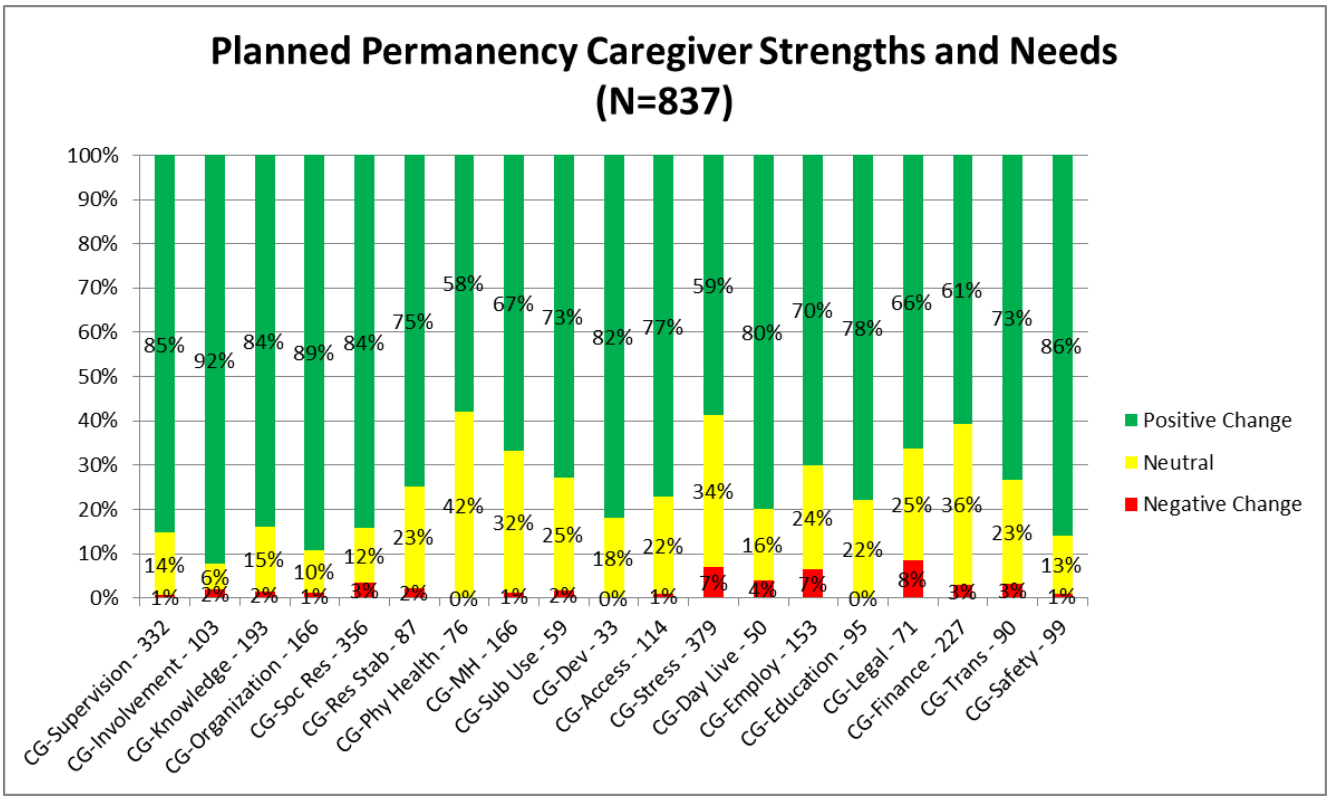
Functional Outcome Goal 2: Children participating in CSA-funded services will experience a decline in behavioral or emotional symptoms that cause severe/dangerous problems.



Functional Outcome Goal 3: Children participating in CSA-funded services will experience an increase in identified strengths that are useful in addressing their needs and developing resiliency.



Functional Outcome Goal 4: Needs and issues of parents/caregivers of children participating in CSA-funded services that negatively impact their care-giving capacity will be reduced.



Fairfax-Falls Church CPMT Mission and Principles

Mission: To provide leadership in the development of new concepts and approaches in the provision of services to children, youth and families of Fairfax County and the Cities of Fairfax and Falls Church. The primary focus of the CPMT is to lead the way to effective and efficient services for the children already or at risk of experiencing emotional/behavioral problems, especially those at risk of or in need of out of home placements, and their families.

Philosophy: ***The most important community responsibility is the well-being of children.*** Children belong with families who nurture and protect them, children deserve healthy relationships, and families deserve to live in safe environments.

CPMT Principles	Systems of Care Principles
***Services are supportive to children and their families*, providing them with the opportunity to succeed in the community to the fullest extent possible;**	***Our system will support families* to fulfill their primary responsibility for the safety, the physical and emotional health, the financial and educational wellbeing of their children.**
Needs of children and families will be met in the least restrictive way*, with families fully participating in the decision making process;** ***The family unit will remain intact whenever possible*, and issues are to be addressed in the context of the family unit;** **Services will be community-based whenever possible, and *children will be placed outside of the community only when absolutely necessary.	***Children are best served with their own families*. Keeping children and families together and preventing entry into any type of out of home placement is the best possible use of resources.**
***All agencies providing services will work together, cooperatively, with each other and with the family*, to gain maximum benefit from the available resources.**	**Our system embraces the concepts of shared resources, decision making and responsibility for outcomes. *All stakeholders will work together collaboratively with each other and the family* to gain maximum benefits from available resources.**
Services are flexible and comprehensive to meet the individual needs of children and families;	***Children and families will receive individualized services in accordance with expressed needs.***
***Services are easily accessible to residents of the community, regardless of where they live, their native language or culture,* their level of income, or their level of functioning;**	***Our families will receive culturally and linguistically responsive services*.**
***Services are integrated into the community*, in the neighborhoods where the people who need them live;**	***Children with emotional, intellectual or behavioral challenges will receive integrated services and care coordination* in a seamless manner.**
Services are family focused to promote the well-being of the child and community;	***Our system will be youth guided and family driven* with the family identifying their own strengths and needs and determining the types and mix of services and desired outcomes within the resources available.**
Services are responsive to people and adaptable to their changing needs;	***County, community and private agencies will embrace, value, and celebrate the diverse cultures of their children, youth and families* and will work to eliminate disparities in outcomes.**
Services are provided through collaborative and cooperative partnerships between people living in their community and public and private organizations.	***We will be accountable at the individual child and family, system, and community levels for desired outcomes, safety and cost effectiveness.***

Fairfax-Falls Church Community Policy and Management Team

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Deputy County Executive

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Parent Representative

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City of Fairfax

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Robert A. Bermingham, Jr.
Director of Court Services, Juvenile and Domestic Relations District Court

VACANT
Executive Director
Fairfax-Falls Church Community Services Board

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Department of Special Services
Fairfax County Public Schools

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Jessie Georges
Parent Representative

Elizabeth Germer,
Director, Special Education & Student Services, Falls Church City Schools

Kelly Henderson
Parent Representative

M. Gail Ledford,
Director,
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Private Provider/NOVACO Representative

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Phillips Family Partners
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COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES

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Phone: (703) 324-7938
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CSA System of Care Annual Report
FY 2013
Fairfax-Falls Church Community Policy and Management Team

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